



## College Statement

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Title	<b>Planned breech deliveries at term</b>
Statement No.	<b>C-Obs 11</b>
Date of this document	<b>November 2007</b>
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### **Background - The Term Breech Trial**

The literature is dominated by the large multinational trial of 2088 women with a breech presentation randomised to either planned vaginal birth or elective caesarean section (Hannah et al, 2000). Women with risk factors such as a footling breech, head extension, estimated fetal weight of >4kg or a suspected fetal anomaly or feto-pelvic disproportion were excluded from the study. Perinatal mortality and serious neonatal morbidity were significantly lower in the planned caesarean section group than for the planned vaginal birth group (1.6 per cent vs 5.0 per cent,  $p < 0.0001$ ). Serious maternal morbidity in the study was 3.6 per cent and this did not differ significantly between the planned caesarean section and planned vaginal birth groups.

A subsequent increase in the use of planned caesarean section for breech presentation at term has been associated with substantial improvements in perinatal outcome in this group of patients, with a halving of the perinatal mortality and even greater reductions in the incidence of birth trauma (Rietberg et al, 2005).

### **Recommendations**

1. *External Cephalic Version (ECV)*
  - a. Contraindications to ECV include: caesarean section is indicated on other grounds, oligohydramnios, antepartum haemorrhage, multiple pregnancy (other than after delivery of the first twin), some fetal anomalies, fetal hypoxia, a restrictive nuchal cord, uterine structural anomalies and a uterine scar
  - b. ECV should be performed by suitably trained health professionals where there is facility for emergency caesarean section if needed and according to institutional protocols that define the place of cardiotocography, ultrasound and tocolysis

- c. ECV has low complications rates with approximately 0.5% requiring emergency caesarean section. Studies have not been sufficiently powered to estimate the frequency of uterine rupture, perinatal death or long term morbidity but case reports exist of these outcomes
- d. The success rates of ECV are approximately 40% in nulliparous women and 60% in multiparae.
- e. ECV reduces the caesarean section rate although women having a successful ECV have higher caesarean section rates in labour.
- f. Women with a breech presentation at term, and no contraindications to ECV, should be informed about ECV and offered it if clinically appropriate.

## 2. *Individualise Management*

While it is true that women with breech presentation at term will most often be delivered by caesarean section, management should be individualised. The term breech trial did not have the statistical power to meaningfully analyse subgroups, some of which are likely to be pregnancies that do extremely well with breech vaginal delivery.

## 3. *Factors that may favour a planned vaginal delivery*

- a. Reduced fetal risk from planned vaginal delivery:
  - Continuous fetal heart monitoring in antenatal labour is required.
  - Immediate availability of caesarean facilities if necessary.
  - Availability of a suitably experienced obstetrician.
  - Presume favourable fetal circumstances, eg small or average size, no placental insufficiency, frank breech, appropriate gestational age, documented head flexion.
  - Favourable maternal circumstances, eg adequate pelvis, maternal co-operation with pushing, multiparity.
- b. Increased risk from planned caesarean section:
  - In particular, this would include women planning a large family where a scar on the uterus may have particular serious morbidity in association with placenta praevia accreta in subsequent pregnancies. (Silver et al, 2006).
- c. Strong particular maternal preference for vaginal delivery.

Counselling the patient about the risks and benefits of planned vaginal breech delivery should be undertaken wherever possible.

## References

Planned caesarean section versus planned vaginal birth for breech presentation at term: a randomised multi-centre trial, Hannah ME, Hannah WJ, Hewson SA, Hodnett ED, Saigol S, Willan AR: *Lancet* 2000; 356: 1375-85.

The effect of the Term Breech Trial on medical intervention behaviour and neonatal outcome in the Netherlands: an analysis of 35,453 breech infants. Rietberg CT, Elferink-Stinkens PM, Visser GHA. *BJOG* 2005; 112: 205-9.

Maternal Morbidity Associated with multiple repeat cesarean deliveries. Silver RM, Landon MB, Rouse DJ et al. *Obstet Gynecol* 2006; 107: 1226-32.

Hofmeyr GJ, Kulier R. External cephalic version for breech presentation at term. *Cochrane Database Syst Rev* 2000.

## **Links to other related College Statements**

[C-Gen 2: Guidelines for consent and the provision of information regarding proposed treatment.](#)

### **Disclaimer**

This College Statement is intended to provide general advice to Practitioners. The statement should never be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of each patient.

The statement has been prepared having regard to general circumstances. It is the responsibility of each Practitioner to have regard to the particular circumstances of each case, and the application of this statement in each case. In particular, clinical management must always be responsive to the needs of the individual patient and the particular circumstances of each case.

This College statement has been prepared having regard to the information available at the time of its preparation, and each Practitioner must have regard to relevant information, research or material which may have been published or become available subsequently.

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